

STATEMENT OF FACTS SUMMARY SHEET**A. To Be Completed by Program Office:**

Legal Case #:	Program:_____	
Appeal Rec'd:	Acknowledgment Letter Sent:	SOF Due:

B. To Be Completed by R.O./County

FACILITY #:		CAPACITY:	OPERATING? YES / NO	FACILITY TYPE (Choose 1)	
Decertified or Excluded Individual	Last, First MI		Phone ()	<input type="checkbox"/> 400 AA <input type="checkbox"/> 740 RCFE <input type="checkbox"/> 430 FFA <input type="checkbox"/> 772 SRF <input type="checkbox"/> 431FFAsub <input type="checkbox"/> 775 ADP <input type="checkbox"/> 433 CFFH <input type="checkbox"/> 810 FCCH <input type="checkbox"/> 710 SFH <input type="checkbox"/> 830 CCC-INF <input type="checkbox"/> 711 FFH <input type="checkbox"/> 840 CCC-SA <input type="checkbox"/> 720 CN <input type="checkbox"/> 845 CCC-III <input type="checkbox"/> 726 THPP <input type="checkbox"/> 850 CCC <input type="checkbox"/> 728 CTF <input type="checkbox"/> 900 TLR <input type="checkbox"/> 730 GH <input type="checkbox"/> 734 ARFPSHN <input type="checkbox"/> 735 ARF <input type="checkbox"/> 736 RCFCI	
Address	#/Street/City		Zip		
Cert Fam. Home			Phone ()		
Address	#/Street/City		Zip		
Licensee Name			Phone ()	Telephone TSO	Attorney Name:
Address	#/Street/City		Zip	Date Program Administrator/Assistant Program Administrator Approved:	
Facility Name			Phone ()	Immediate Exclusion	Date Served: / /
Address			Zip	Attorney Consulted	Name:

Date First Licensed/Certified:	# of other facilities:	Attach additional summary sheets
CFFH - Date decertified:	Capacity:	Dual Licensure <input type="checkbox"/> Yes <input type="checkbox"/> No

VIOLATIONS (Choose all that pertain)				TYPE OF ACTION REQUESTED			
01 Physical Abuse		11 Food Service		01 Denied Application		15 NonImmed Exc - Admin	
02 Sexual Abuse		12 False Statements		02 Telephone TSO		16 NonImmed Exc - Other	
03 Other Persons Rights/Restraints		13 Medications		03 TSO		17 Denied Exemption Action	
04 Unlicensed		14 Financial Abuse		04 Revocation		18 Admin Decert.	
05 Fire Clearance		15 Level of Care		41 Expedited Revocation			
06 Crimes - no arrest		16 Qualifications		05 Inj/TRO			
61 Crimes-Conv Exemp Denied		17 Financial Issues		06 Attorney Review			
62 Crimes-Non Exemptible		18 Questionable Death		08 Revoke Prob			
63 Crimes-Arrest Only		19 Other		09 FFA Certified Family Action			
07 Physical Plant		21 Ritualistic Abuse		11 Immed. Exc-Employee			
08 Record Keeping		22 Physical Punishment		12 Immed. Exc-Administration			
09 License/Cap.		23 CAIC Match		13 Immed. Exc-Other			
10 Neglect/Lack of Sup		24 Conduct Inimical		14 NonImmed Exc-Employee			
		25 Failure To Pay Initial and/or Annual Fees					

FOR STATE CASES ONLY

IB INVOLVED? <input type="checkbox"/> YES <input type="checkbox"/> NO	CASE #:	CASE #:	CASE #:
AUDITOR SERVICES? <input type="checkbox"/> YES <input type="checkbox"/> NO	AUDITOR NAME:	CIVIL PENALTIES? <input type="checkbox"/> YES <input type="checkbox"/> NO	SOC 341 SUBMITTED <input type="checkbox"/> YES <input type="checkbox"/> NO

Referring Regional Office Name:

	Last	First	Phone:
LPA Name:			()
Supervisor Name:			()
R.O./County Manager Signature/Approval:			Date:
Program Administrator/Assistant Program Administrator Signature/Approval:			Date:

For TSO requests, address each of these five areas in the *Comments* section below:

- 1) Projected date of closure;
- 2) Local agencies that need to be involved;
- 3) Press involvement to date;
- 4) Local legislative offices notified;
- 5) Other important information.

Comments
<p>Licensee status? (Private, non-profit, for-profit corporation?).</p> <p>Note companion cases and referral to other Programs, if any.</p> <p>For actions against individual, list other facility associations, if any.</p> <p>Individual PIN (LIS ID #).</p> <p>Note any LAARS associations, if any.</p>

C. CASE SUMMARY

D. SPECIAL ISSUES/PERTINENT INFORMATION

E. INFORMAL CONFERENCE(S)/LICENSEE INTERVIEW

F. WITNESSES

1. NAME:			DRIVER LICENSE NUMBER:		
ADDRESS:		NUMBER	STREET	CITY	ZIP
WORK PHONE () -		HOME PHONE () -		DATE OF BIRTH: - -	
RELATIONSHIP TO FACILITY:					

2. NAME:			DRIVER LICENSE NUMBER:		
ADDRESS:		NUMBER	STREET	CITY	ZIP
WORK PHONE () -		HOME PHONE () -		DATE OF BIRTH: - -	
RELATIONSHIP TO FACILITY:					

3. NAME:			DRIVER LICENSE NUMBER:		
ADDRESS:		NUMBER	STREET	CITY	ZIP
WORK PHONE () -		HOME PHONE () -		DATE OF BIRTH: - -	
RELATIONSHIP TO FACILITY:					

4. NAME:			DRIVER LICENSE NUMBER:		
ADDRESS:		NUMBER	STREET	CITY	ZIP
WORK PHONE () -		HOME PHONE () -		DATE OF BIRTH: - -	
RELATIONSHIP TO FACILITY:					

5. NAME:			DRIVER LICENSE NUMBER:		
ADDRESS:		NUMBER	STREET	CITY	ZIP
WORK PHONE () -		HOME PHONE () -		DATE OF BIRTH: - -	
RELATIONSHIP TO FACILITY:					

6. NAME:			DRIVER LICENSE NUMBER:		
ADDRESS:		NUMBER	STREET	CITY	ZIP
WORK PHONE () -		HOME PHONE () -		DATE OF BIRTH: - -	
RELATIONSHIP TO FACILITY:					

G. WITNESSES

1. NAME:			DRIVER LICENSE NUMBER:	
ADDRESS:	NUMBER	STREET	CITY	ZIP
WORK PHONE () -	HOME PHONE () -		DATE OF BIRTH: - -	
RELATIONSHIP TO FACILITY:				

2. NAME:			DRIVER LICENSE NUMBER:	
ADDRESS:	NUMBER	STREET	CITY	ZIP
WORK PHONE () -	HOME PHONE () -		DATE OF BIRTH: - -	
RELATIONSHIP TO FACILITY:				

3. NAME:			DRIVER LICENSE NUMBER:	
ADDRESS:	NUMBER	STREET	CITY	ZIP
WORK PHONE () -	HOME PHONE () -		DATE OF BIRTH: - -	
RELATIONSHIP TO FACILITY:				

4. NAME:			DRIVER LICENSE NUMBER:	
ADDRESS:	NUMBER	STREET	CITY	ZIP
WORK PHONE () -	HOME PHONE () -		DATE OF BIRTH: - -	
RELATIONSHIP TO FACILITY:				

5. NAME:			DRIVER LICENSE NUMBER:	
ADDRESS:	NUMBER	STREET	CITY	ZIP
WORK PHONE () -	HOME PHONE () -		DATE OF BIRTH: - -	
RELATIONSHIP TO FACILITY:				

6. NAME:			DRIVER LICENSE NUMBER:	
ADDRESS:	NUMBER	STREET	CITY	ZIP
WORK PHONE () -	HOME PHONE () -		DATE OF BIRTH: - -	
RELATIONSHIP TO FACILITY:				

STATEMENT OF FACTS (SOF) SUMMARY SHEET INSTRUCTIONS

THE SOF SUMMARY SHEET PROVIDES BASIC INFORMATION TO BE ENTERED INTO THE LEGAL CASE TRACKING SYSTEM (LCTS). THE LCTS PROVIDES A MECHANISM FOR TRACKING LEGAL CASES THROUGHOUT THE PROCESS.

TO BE COMPLETED BY PROGRAM OFFICE:

Legal Case Number: Enter a 9 to 11 digit case number, which remains with case throughout legal action.

PROGRAM: Enter appropriate program - Child Care, Childrens Residential, Adult Care, Senior Care

Appeal Rec'd: Enter date Program Office received appeal for: exclusion, de-certification, denial of application, or denial of exemption.

Acknowledgment Letter Sent: Enter date acknowledgment letter was sent to appellant.

SOF Due: Enter date SOF is due from R.O., CBCB, or County staff.

TO BE COMPLETED BY R.O./COUNTY:

Facility number: Enter facility number that R.O./County has assigned to facility.

Capacity: Enter capacity for which facility is licensed.

Operating?: Circle yes if facility is currently operating. Circle no if facility is not currently operating.

Facility type: Check appropriate facility type.

Decertified or Excluded Individual: Enter last name/first name, address, and phone number of decertified or excluded individual.

FFA Certified Family Home: Enter the name, address, and phone number of the Certified Family Home (last name/first name) when an FFA decertification action is being taken.

Licensee Name: Enter licensee's last name/first name, (or corporate name as shown on license), mailing address, and phone number.

Facility Name: Enter facility's name (**as shown on license**), address, and phone number.

Telephone TSO: Enter assigned attorney's name and date approved by Program Administrator.

Immediate Exclusion: Enter date letter was sent to individual and the name of attorney that was consulted.

Date first licensed: Enter date the first license was issued.

of other facilities: If licensee operates more than one facility, enter the number of additional facilities and attach an additional summary sheet and LIS profile for each facility. Enter "O" if there are no other facilities.

VIOLATIONS:

01 Physical Abuse: Subject kicking, punching, slapping, hitting, hitting with an object, squeezing, pushing, with intent to do physical harm to victim.

02 Sexual Abuse: Inappropriate sexual activity between a client and non-client including rape, molestation, sodomy, voyeurism, pornography or sexual harassment.

03 Other Personal Rights/Restraint: Verbal or emotional abuse (excluding #22 Physical Punishment below), intimidation, interference with daily living such as eating or sleeping, locking clients in or out or using other restraints.

04 Unlicensed: Providing unlicensed care.

05 Fire Clearance: Operating a facility without an appropriate fire clearance.

06 Crimes - no arrest: Criminal conduct which did not result in an arrest or conviction.

61 Crimes - Conv Exempt Denied: Denial of exemption due to conviction.

62 Crimes - Non Exemptible: Denial of exemption due to non-exemptible crime.

63 Crimes - Arrest Only: Action taken as a result of the arrest only investigation.

07 Physical Plant: Unsafe or unsanitary buildings or grounds including unfenced pool, poor repair, heating, lighting, cooling, or lack of phone or signal system.

08 Record Keeping: Inadequate client or staff records including medical, staff qualifications, admission agreement, or other required records.

09 License/Capacity: Operating beyond terms of license including overcapacity. Excludes Level of care.

10 Neglect/Lack of Supervisor: Lack of adequate staff to provide aid with daily living including dressing, bathing, feeding, transportation, or medical needs. Failure to protect clients from harm.

11 Food Service: Failure to provide adequate food service including poor food, special diets, menu planning, etc.

12 False Statements: Providing false information on application, lying about facility incidents or submitting false reports about clients.

13 Medications: Mishandling of medications including poor storage, dispensing, labeling or record keeping.

SOF SUMMARY SHEET INSTRUCTIONS

(Continued)

- 14 Financial Abuse:** Misuse of client cash resources such as P&I, gifts, SSI/SSP checks or failure to protect client's personal property.
- 15 Level of Care:** Accepting/retaining clients requiring higher level of care than allowed in a non-medical facility or by the license.
- 16 Qualifications:** Persons providing services not meeting required qualifications.
- 17 Financial Issues:** Lack of resources to operate facility within licensing requirements or other non-client financial issues.
- 18 Questionable Death:** Client's death where it appears the facility could have been responsible or could have done more to prevent death.
- 19 Other:** All violations which do not fit into other categories.
- 21 Ritualistic Abuse:** Physical, emotional, psychological, sexual abuse in a ritualistic manner.
- 22 Physical Punishment:** Spanking on bottom, slapping on back of hand, etc. (not rising to the level of #01 Physical Abuse above).
- 23 CACI Match:** Actions taken as a result of a CACI match and subsequent substantiated violation.
- 24 Conduct Inimical:** Conduct which is inimical to the health, morals, welfare, or safety of either an individual in, or receiving services from, the facility or the people of the State of California.
- 25. Failure To Pay Initial and/or Annual Fees.**

TYPE OF ACTION REQUESTED:

- 01 Denied Application:** Denial of an application. OK to include Attorney Review (06) if necessary. However, for any other actions taken against the same licensee (i.e., revoking additional licenses), a SOF Summary Sheet must be completed for each action.
- 02 Telephone TSO:** Imminent danger has been established and an attorney is assigned prior to receiving case. Note above reference to Telephone TSO. Must include Revocation (04).
- 03 TSO:** Imminent danger has been established. Must include Revocation (04); OK to include Attorney Review (06).
- 04 Revocation:** License is to be revoked. OK to include Attorney Review (06). However, for any other actions taken against the same license (i.e., revoking additional licenses or excluding an employee, etc.), an additional SOF Summary Sheet must be completed for each action.
- 41 Expedited Revocation:** Use to request priority action on an accusation.
- 05 Injunction/TRO:** Request to legal to request the court to enjoin or temporarily restrain a facility from operating without a license.
- 06 Attorney Review:** Use when requesting attorney review. Most often is used in conjunction with another action type.
- 08 Revoke Probl.:** Probation is to be revoked. OK to include Attorney Review (06).
- 09 FFA Certified Family Home Action:** Use when de-certifying or requesting that a home not be certified.
- 11 Immediate Exclusion - Employee:** Use when an employee has been or will be immediately excluded. Must complete date served and attorney consulted. OK to include Attorney Review (06) when letter has not been served.
- 12 Immediate Exclusion - Administrator:** Use when an Administrator has been or will be immediately excluded. Must complete date served and attorney consulted. OK to include Attorney Review (06) when letter has not been served.
- 13 Immediate Exclusion - Other:** Use when a family member or non-client adult has been or will be immediately excluded. Must complete date served and attorney consulted. OK to include Attorney Review (06) when letter has not been served.
- 14 Non-Immediate Exclusion - Employee:** Use to request non-immediate exclusion of an employee. OK to include Attorney Review (06).
- 15 Non-Immediate Exclusion - Administrator:** Use to request non-immediate exclusion of an Administrator. OK to include Attorney Review (06).
- 16 Non-Immediate Exclusion - Other:** Use to request non-immediate exclusion of a licensee, board member, family member or non-client adult. OK to include Attorney Review (06).
- 17 Denied Exemption Action:** To be used by CBCB when a criminal record exemption has been denied. Could be used in conjunction with immediate or non-immediate exclusion.
- 18 Administrator Decertification:** Not currently being used. Reserve for future use.

SOF SUMMARY SHEET INSTRUCTIONS

(Continued)

FOR STATE CASES ONLY:

IB Involved: Circle Yes or No. If yes, enter all investigation report numbers. If more than 3, include in comment section.

Audit Services: Circle Yes or No. If yes, enter auditor's name, if known.

Civil Penalties: Circle Yes or No.

SOC 341 Submitted: Circle Yes or No.

FOR ALL CASES:

Referring R.O. or County: Enter R.O. or county name.

Analyst's Name: Enter Analyst's last name/first name and phone number.

Supervisor Name: Enter Supervisor's last name/first name and phone number.

R.O./CBCB/County Manager Signature: R.O., CBCB or County Manager signs and dates document.

Program Administrator/Assistant Program Administrator Signature: Program Administrator/Assistant Program Administrator signs and dates document.

Comments: Enter any additional comments necessary.

FACILITY TYPES:

400 - AA Adoption Agency

430 - FFA Foster Family Agency

431 - FFAsub Foster Family Agency Suboffice

433 - CFFH Certified Foster Family Home

710 - SFH Small Family Home

711 - FFH Foster Family Home

720 - CN Crisis Nursery

726 - THPP Transitional Housing Placement Program

728 - CTF Community Treatment Facility

730 - GH Group Home

734 - ARFPSHN Adult Residential Facility for Persons with Special Health Care Needs

735 - ARF Adult Residential Facility

736 - RCF-C1 Residential Care Facility for the Chronically III

740 - RCFE Residential Care Facility for the Elderly

772 - SRF Social Rehabilitation Facility

775 - ADC Adult Day Care

776 - ADSC Adult Day Support Center

810 - FCCH Family Child Care Home

830 - CCC-I Child Care Center - Infant

840 - CCC-SA Child Care Center - School Age

845 - CCC-III Child Care Center - III Children

850 - CCC Child Care Center